STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	))))))
Docket No. INS-06-900	

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IN RE: DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR	**)** **)** **)** **)**	**REPLY BRIEF OF THE MAINE ASSOCIATION OF HEALTH PLANS**
Docket No. INS-06-900		July 7, 2006

Pursuant to the Superintendent's Notice of Pending Proceeding and Hearing dated April 26, 2006, and Order on Intervention and Procedures dated June 15, 2006, the Maine Association of Health Plans ("MEAHP") submits this Reply Brief with respect to the June 6, 2006 written decision (the "Decision") by the Board of Directors (the "Board") of the Dirigo Health Agency ("DHA") finding $41,757,000 in aggregate measurable cost savings ("AMCS") for the second assessment year ("year 2").

On June 23, MEAHP and other intervenors – Anthem Health Plans of Maine, Inc. ("Anthem"), the Maine State Chamber of Commerce (the "Chamber"), and the Maine Automobile Dealers Association Insurance Trust (the "Trust") – filed thorough briefs outlining in detail the numerous reasons why the Decision is not reasonably supported by evidence in the record. MEAHP will not restate the arguments it has already posited, but will simply respond to the unpersuasive and limited briefs filed by Consumers for Affordable Health Care ("CAHC") and the Board.

As an intervenor allied with DHA, CAHC filed a brief on June 23, but in so doing relied largely on a document – a post-hearing analysis of the Decision crafted by DHA's consultant, Mercer Government Human Services Consulting ("Mercer") – that the Superintendent has

already ruled is inadmissible. It is elementary, then, that the Superintendent should ignore CAHC's brief to the extent it mentions or relies upon an inadmissible document.

In response to the briefs from MEAHP, Anthem, the Chamber, and the Trust, the Board filed a brief on June 30 that offers only the most meager *ipse dixit* argument, essentially saying "our decision is reasonable because we say it is, and you should defer to our judgment on the matter." The Board's argument (a) inappropriately limits the Superintendent's role in this proceeding and (b) is blind to the record evidence in this case. Quite simply, (a) the Superintendent has an active role to play in this proceeding, particularly given the significant reasons why the Board's Decision is due no deference, and (b) the record evidence, no matter how it is viewed, does not reasonably support the conclusion that AMCS for year 2 is $41,757,000.

I. PROCEDURAL ISSUES

A. The Superintendent should give the Board's Decision no deference.

The Board goes to great lengths in its brief to cast the Superintendent in the role of a sword-less matador who should be content to wave a red cape as the Decision passes by. But the Superintendent is not unarmed; he carries a sword with which he may cut down the Decision if he finds it is not reasonably supported by evidence in the record. According to the simple terms of the Act, the Superintendent is charged with determining whether and to what extent the Board's Decision is reasonably supported by the evidence in the record. 24-A M.R.S.A. §6913(1). It is for the Superintendent to review the record in this case, and then decide for himself whether the Decision is reasonably supported. Nowhere does the Act, either directly or even indirectly, suggest that the Superintendent should give the Board's Decision any deference. Similarly, nowhere does the Act, either directly or even indirectly, import the "arbitrary and

capricious" standard of review. Despite the Board's attempt at semantic gymnastics, "reasonable" is not a euphemism for "arbitrary and capricious." If the legislature had intended for the Superintendent to apply a deferential "arbitrary or capricious" standard, it could have chosen those words. But it did not; the Legislature charged the Superintendent with determining whether the record reasonably supports the Decision. The Superintendent, exercising his independent judgment, will determine what is reasonable and what is not.

Indeed, there are several reasons why the Superintendent should review the Board's Decision with considerable skepticism rather than deference.

1. Board's inherent bias toward funding for DHA programs

Independent review by the Superintendent is critical to the process for establishing a reasonable amount of AMCS. DHA draws funding for its programs directly from the savings offset payment ("SOP") which is a function of AMCS, and so the Board has every motivation to inflate its determination of AMCS; the bigger the pot of money in AMCS, the more funding DHA can procure for its programs through the SOP. Without meaningful independent review of the Board's Decision by the Superintendent, the fox is left to guard the henhouse.

2. Board's procedural bias toward DHA and CAHC

Throughout the proceeding before the Board, the Board exhibited improper procedural bias in favor of DHA and CAHC. DHA and CAHC routinely failed to meet deadlines imposed by the Board and the hearing officer prior to the adjudicatory hearing, yet the Board and the hearing officer did little in response and even enabled DHA's and CAHC's dilatory tactics. Despite the Act's clear prescription that the Board make its determination of AMCS by April 1, the Board saw fit to allow DHA's Motion to Continue the hearing until sometime after August 15, 2006; only a ruling by an independent body – Superior Court Justice Marden – could set the

Board straight and ensure that the adjudicatory hearing took place as soon as practicable after the April 1 deadline which had already passed.

The Board's incredible inability to ensure a fair process also comes to light in the context of document production. Months before the adjudicatory hearing was to commence, MEAHP and Anthem sought rudimentary discovery from DHA. The Board ruled that intervenors could take discovery from DHA only via a FOAA request, and so MEAHP and Anthem both served DHA with FOAA requests in February. DHA's response was appalling, and was enabled by the Board. DHA did not produce any substantive documentation in response to the FOAA until April 18, and did not produce substantial amounts of documentation until after 5 p.m. on May 2 (only three business days prior to commencement of the hearing) and even after 8 p.m. on May 8 (after the first day of the hearing was completed). Most disturbingly, the documentation that DHA did not produce to intervenors until May 2 and May 8 (Medicare Cost Reports, "MCRs") was produced by DHA to its own expert, Kevin Russell, on April 24. If DHA had the documentation on April 24, why didn't it produce the documentation to the intervenors until May 2 and 8?[1]

In the face of DHA's utter failure to produce the MCRs until the very last moment, the Board melted. Rather than rule that DHA's failure to produce the MCRs in an even remotely timely manner had prejudiced the intervenors' ability to prepare for the hearing so significantly that the MCRs could not be introduced into evidence at the hearing, the Board simply adjusted the schedule of topics and witnesses so that the MCRs would not come up until the second day of the hearing, May 10. As a result, the Board allowed intervenors approximately 36 hours, in the

[1] In contrast to DHA's months-long foot-dragging in response to the intervenors' FOAA requests, DHA responded to a recent FOAA request from CAHC *the very next day!* This circumstance is outrageous, and further suggests an inappropriately close relationship between DHA and CAHC. Thankfully, the Superintendent has ruled that the information sought by CAHC should not be part of the record in this case.

midst of preparation for the second day of the hearing, to review newly disclosed documents that were central to DHA's position. This tortured disclosure process fundamentally violated the intervenors rights to due process and a fair hearing, yet the Board took no meaningful action. As a result, the Board cannot be perceived as a reliable arbiter of AMCS, and so it is essential that the Superintendent exercise independent judgment based on the evidence properly in the record.

3. Bias of Board member Ned McCann in favor of DHA and CAHC

Recently it has come to light that Ned McCann, a member of the Board who voted in favor of the Board's Decision, also is on the board of directors of CAHC. Mr. McCann's dual roles clearly present a significant conflict of interest, yet neither the Board, nor DHA, nor CAHC, nor Mr. McCann himself brought this issue to the attention of either counsel for the intervenors or the hearing officer. Instead, the intervenors learned of Mr. McCann's position with CAHC by happenstance – a piece of correspondence from CAHC (dated June 16, 2006) carried letterhead listing the members of the Board of Director's, including Mr. McCann. Even setting aside, for the moment, the notion of Mr. McCann's possible bias, it is astounding that nobody saw fit to inform counsel for the intervenors of Mr. McCann's clear conflict; others on the Board, including Dana Connors of the Chamber, recused themselves because of possible bias, yet Mr. McCann, the Board, DHA, and CAHC remained mute to Mr. McCann's dual role. And given Mr. McCann's dual roles, a thick veil of possible bias hangs heavily over the Decision. The Superintendent must lift this veil and look upon the Board's Decision with an independent, critical, and even skeptical eye.

B. The Superintendent should ignore CAHC's brief to the extent it relies on an inadmissible document.

CAHC's brief challenges only one aspect of the Board's Decision – its use of a median growth rate to calculate putative savings allegedly related to CMAD. In making its argument,

however, CAHC relies almost entirely on a document that the Superintendent has already ruled is inadmissible. Therefore, the Superintendent should ignore CAHC's brief to the extent it mentions or relies upon an inadmissible document.

On June 19, CAHC filed a motion with the Superintendent seeking leave to serve information requests and/or present additional evidence. Without waiting for a ruling from the Superintendent, CAHC went ahead and served a FOAA request on DHA the very next day, June 20, seeking specifically any post-hearing analyses of the Board's Decision. In startling contrast to the several months it took DHA to respond to FOAA requests from MEAHP and Anthem, and again without waiting for a ruling from the Superintendent, DHA responded to CAHC's FOAA request the very next day, June 21, by producing a post-hearing analysis of the Board's Decision by DHA's consultant, Mercer. This document is now at the heart of pages 5 through 8 of CAHC's brief and is attached thereto as Exhibit 3.

By Order dated June 26, however, the Superintendent denied CAHC's motion for leave to serve information requests and/or present additional evidence. By the same Order, the Superintendent denied DHA's motion for leave to present additional evidence. The thrust of the Superintendent's June 26 Order was that he must review the record as it existed before the Board, and so it would be improper for him to review additional information that was not available to the Board.

As a result of the Superintendent's June 26 Order, CAHC's FOAA request and DHA's response are entirely nugatory. CAHC may have anticipated a ruling from the Superintendent in its favor and so felt secure filing a brief that was dependant upon additional information outside the record, but the reality is that CAHC's brief is in violation of the Superintendent's June 26

Order. As a result, to the extent it mentions or relies upon inadmissible information, the Superintendent should ignore CAHC's brief.

II. SUBSTANTIVE ISSUES

A. AMCS is limited to the categories set forth in §6913(1) of the Act.

The Superintendent has taken the position that his role is only to make factual determinations based on his review of the record as it was presented to the Board in the hearing on May 8 and 10. In so doing, and consistent with his ruling regarding Year 1, the Superintendent has indicated that he will not interpret the Act in order to determine which categories of savings should be included in AMCS. Instead, the Superintendent seems inclined to accept, without any review, the Board's inclusion of various categories of savings, leaving him to review only the reasonableness of the amount of putative savings claimed for each category. If this is indeed the case, then the Superintendent should state explicitly that he is not ruling on whether any of the categories of savings recognized by the Board are, as a matter of law, to be included in AMCS.

But if the Superintendent undertakes to determine whether any of the categories of putative savings recognized by the Board actually are countenanced in the Act as components of AMCS, he should conclude that only those categories set forth in §6913(1) of the Act are included in AMCS. Section 6913(1) prescribes that AMCS shall include

> any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1). Accordingly, the only category of putative savings set forth in §6913(1) is Uninsured Initiatives.

In its Decision, the Board recites no other statutory basis for the inclusion of any other categories of savings within AMCS. Instead, as noted in pages 7-16 of MEAHP's Brief, the Board relies on perfunctory references to the merest penumbras and vaguest emanations from the Act as the foundation for including various categories within AMCS. Quite simply, The Board's meek justifications for including categories other than Uninsured Initiatives do not pass muster and should be rejected by the Superintendent.

B. If AMCS is not limited to the categories set forth in §6913(1) of the Act, then it is unconstitutionally vague.

A statute is unconstitutionally vague if it "would force men of general intelligence to guess at its meaning, … and forc[e] courts to be uncertain in their interpretation of the law." Shapiro Brothers Shoe Co., Inc. v. Lewiston-Auburn Shoeworkers Protective Association, 320 A.2d 247, 253 (Me. 1973). See, e.g., Town of Baldwin v. Carter, 2002 ME 52, ¶ 9, 794 A.2d 62, 67; Bushey v. Town of China, 645 A.2d 615, 618 (Me. 1994), citing Maine Milk Producers, 483 A.2d at 1220; Brasslett v. Cota, 761 F.2d 827, 838 (1st Cir. 1985). The rationale for such a principle is clear: "Without definite standards an ordinance becomes an open door to favoritism and discrimination." Waterville Hotel Corp. v. Board of Zoning Appeals, 241 A.2d 50, 53 (Me. 1968). By arguing that AMCS is not limited to Uninsured Initiatives according to §6913(1), and by sweeping various unrelated categories into AMCS in order to create a large amount of putative savings, the Board has proven the principle.

In a most perplexing maneuver, the Board now argues that its position is not unconstitutional because it "did not decide conclusively what initiatives may or may not be included in AMCS but only decided whether the initiatives presented [by DHA] should be included in AMCS for the second assessment year." Board's Brief, p.7. Again, the Law Court's pronouncement in Waterville Hotel Corp. bears repeating: "Without definite standards an

ordinance becomes an open door to favoritism and discrimination." 241 A.2d at 53. If the Board refuses to take a stand as to what constitutes AMCS, then the Act remains "an open door to favoritism and discrimination." Id. And as such, it would be unconstitutionally vague.

C. The Board has no idea what portion, if any, of the putative $14.5 million in CMAD savings is even slightly related to Dirigo.

Even if one accepts the Board's dubious premise that any putative savings somehow remotely connected to "Dirigo" may be counted as savings within AMCS, there is no reasonable support in the record for the Board's finding of any savings for the Hospital Savings Initiatives. The Board has admitted that its calculation of CMAD "captured savings from Dirigo and other factors and captured negative savings, none of which can be attributed to Dirigo." Board's Brief, p.10. This is all one needs to know in order to conclude that the Board's calculation of $14.5 million in putative savings related to CMAD is fundamentally unreasonable. The Board offered a calculation of savings that includes three component parts – (a) "savings from Dirigo," (b) "savings from … other factors," and (c) "negative savings, none of which can be attributed to Dirigo" – without any effort to parse the dollar figures among these three components. From this calculation, it is impossible to tell what portion of the $14.5 million is related to Dirigo and what portion is related "other factors." Could it be that "other factors" are responsible for a large portion or even all of the $14.5 million? The Board has no idea.[2] As a result, its calculation of $14.5 million in putative savings related to CMAD is patently unreasonable.

As the sole basis for its conclusion that $14.5 million in CMAD savings was Dirigo-related, the Board relied on the testimony of Steven Michaud, President of the Maine Hospital Association; but Mr. Michaud's testimony is unequivocal that Dirigo had nothing to do with any putative CMAD savings. Under questioning regarding the source of the MHA's voluntary

[2] There is a great deal of evidence in the record supporting the proposition that many factors other than Dirigo contribute to fluctuations in the cost of health care. See MEAHP's Brief, pp. 22-28.

decision to limit cost growth in year 2, Mr. Michaud stated: "We can keep going all day on this. The answer is this: In the second year, the Maine Hospital Association, not Dirigo, not the state of Maine, nobody else, established a voluntary cap for hospital expenses. That's the answer. Not Dirigo related; 100% Maine Hospital Association related." R-5148. Since the only evidence in the record on the matter supports the conclusion that no putative CMAD savings are related to Dirigo, it follows that the Board's contrary conclusion is not reasonably supported by record evidence.

D. The Board has no idea how "crowd out" might affect the putative $3.9 million in savings related to MaineCare expansion.

In response to the intervenors' assertion, supported by numerous citations to evidence in the record, that MaineCare expansion would "crowd out" people previously insured, see, *e.g.*, MEAHP's Brief, p. 31, the Board says only that "[i]t is highly unlikely that persons who enrolled in MaineCare were previously insured." Board's Brief, p. 13. In support of its pronouncement that such "crowd out" is "highly unlikely," the Board offers absolutely no record evidence – none. This naked assertion, without support from any evidence in the record and in the face of contrary record evidence as recited by MEAHP and others, is entirely intolerable and simply cannot reasonably support a finding of $3.9 million in putative savings.

E. The Board is counting $5.4 million in putative CON/CIF savings which will reappear as CMAD savings in future years.

In its Brief, the Board has acknowledged that costs of hospital construction projects will be counted twice – once in Year 2 as CON/CIF savings and again as future CMAD savings – unless the future CMAD savings amount is adjusted. In its own words, the Board's brief states: "With regard to future CMAD calculations, it will be necessary to account for savings back in the measuring year in which construction begins and costs are incurred." Board's Brief, p. 15.

But by the Board's own admission, it will be impossible to adjust CMAD in future years to reflect CON/CIF savings in Year 2 because, as noted above, the Board cannot even identify the amount of savings attributable to any of the three general component parts of CMAD. Thus, the Board's calculation of $5.4 million in putative savings related to CON/CIF in Year 2 is entirely unreasonable because it is destined to be counted again in future years as CMAD.

In addition to this unavoidable double-counting problem, the Board's calculation of savings related to CON/CIF is entirely speculative because it intends to count savings that have not even accrued yet, and will not do so for at least three more years. In its own special way, the Board seems to believe that by taking the present value of putative savings that may or may not exist in the future, that present value is no longer entirely speculative. But that simply does not make any sense; the present value of a speculative number is simply an entirely speculative present value. And because it is entirely speculative, the Board's calculation of $5.4 million in CON/CIF savings is not reasonably supported by record evidence.

F. The Board's rationale for counting putative savings related to Provider Fee Initiatives is not based in reality.

The Board believes that it can count the time-value of payments to providers of amounts already owed them as savings simply because such payments are made earlier than the state would like. In so doing, the Board simply has set up the providers as a pass-through accounting device. In the Board's construction, the money flows directly from the state to the providers to the payors to DHA. This circular accounting begs a simple question – why doesn't the state simply make the payments directly to DHA?

Moreover, the Board has admitted that it is counting as putative savings dollars that may never be passed on to payors. See Board's brief, p. 16. Instead, they simply believe that the increased payments put money into the system which payors should negotiate to recoup. See

Board's brief, p. 16. But there is no record evidence that such negotiations ever happen in any meaningful way. Instead, the unrefuted testimony is that Anthem, for instance, pays physician according to a standardized fee schedule. R-5098. Finally, it is just absurd for the Board to recognize, as it does, that "physicians have not received a fee increase in twenty years", and then expect physicians to enable payors to recoup all of the recent increase as savings according to Dirigo.

CONCLUSION

For all of the reasons set forth above, and for all of the reasons set forth more fully in MEAHP's brief as well as the briefs of intervenors Anthem, the Chamber, and the Trust, the Superintendent should:

1. reject the Board's determination of AMCS for the second assessment year in its entirety because it is predicated upon unacceptable violations of due process;

2. reject all of the savings initiatives contained in the Board's determination of AMCS for the second assessment year except for the Uninsured Initiatives because only the inclusion of Uninsured Initiatives in AMCS is reasonably supported by evidence in the record; and/or

3. reject the Board's determination of $41,757,000 because it is not reasonably supported by evidence in the record and issue its own determination of AMCS that is reasonably supported by evidence in the record.

Dated: July 7, 2006

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CERTIFICATE OF SERVICE

I, D. Michael Frink, hereby certify that on July 7, 2006 (before 3:00 p.m.), the foregoing document titled Reply Brief of the Maine Association of Health Plans was served electronically and two copies served via U.S. mail upon:

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